

1-1-2012

## Outpatient Commitment: The Role of Counsel in Preserving Client Autonomy

R. A. Bernfeld

Follow this and additional works at: <https://dc.suffolk.edu/jtaa-suffolk>



Part of the [Litigation Commons](#)

---

### Recommended Citation

17 Suffolk J. Trial & App. Advoc. 352 (2012)

This Notes is brought to you for free and open access by Digital Collections @ Suffolk. It has been accepted for inclusion in Suffolk Journal of Trial and Appellate Advocacy by an authorized editor of Digital Collections @ Suffolk. For more information, please contact [dct@suffolk.edu](mailto:dct@suffolk.edu).

# OUTPATIENT COMMITMENT: THE ROLE OF COUNSEL IN PRESERVING CLIENT AUTONOMY

## I. INTRODUCTION

As long-term institutionalization for mentally ill people became disfavored, states began to develop programs for involuntary outpatient commitment (“IOC”)<sup>1</sup> to provide treatment for mental illness.<sup>2</sup> IOC statutes allow a court to order outpatient treatment for a mentally ill person who can live safely in the community while being treated.<sup>3</sup> Such court-mandated treatment usually consists of psychiatric medication, but may also include services such as psychotherapy or case management.<sup>4</sup> In most states, IOC is subject to the same criteria as involuntary inpatient commitment, and is considered the least restrictive alternative to inpatient hospitalization or as a conditional release for patients who are being released from hospitalization.<sup>5</sup>

In addition to providing a less restrictive alternative to institutionalization, some states’ IOC statutes aim to prevent mentally ill

---

<sup>1</sup> Similar laws are sometimes referred to as “assisted outpatient treatment” (“AOT”) or simply as “outpatient commitment” (“OPC”).

<sup>2</sup> See Steven Strang, Note, *Assisted Outpatient Treatment in Ohio: Is Jason’s Law Life-Saving Legislation or a Rash Response?*, 19 HEALTH MATRIX 247, 250-52 (2009) (reviewing history of deinstitutionalization and development of community-based treatment); Kathryn A. Worthington, Note, *Kendra’s Law and the Rights of the Mentally Ill: An Empirical Peek Behind the Courts’ Legal Analysis and a Suggested Template for the New York State Legislature’s Reconsideration for Renewal in 2010*, 19 CORNELL J.L. & PUB. POL’Y 213, 216-17 (2009) (discussing development of outpatient treatment programs in response to deinstitutionalization).

<sup>3</sup> See, e.g., CAL. WELF. & INST. CODE §§ 5345-5349.5 (West 2010); N.Y. MENTAL HYG. LAW § 9.60 (Consol. Supp. 2012); N.C. GEN. STAT. § 122C-271 (2011); see also *Assisted Outpatient Treatment Laws*, TREATMENT ADVOC. CENTER, [http://www.treatmentadvocacycenter.org/index.php?option=com\\_content&task=view&id=39&Itemid=68](http://www.treatmentadvocacycenter.org/index.php?option=com_content&task=view&id=39&Itemid=68) (Jan. 2012) (advocating use of court-ordered treatment to increase medication compliance).

<sup>4</sup> See OFFICE OF MENTAL HEALTH, N.Y. STATE, *KENDRA’S LAW: FINAL REPORT ON THE STATUS OF ASSISTED OUTPATIENT TREATMENT 11* (2005) [hereinafter *FINAL REPORT*], available at [http://www.omh.ny.gov/omhweb/Kendra\\_web/finalreport/AOTFinal2005.pdf](http://www.omh.ny.gov/omhweb/Kendra_web/finalreport/AOTFinal2005.pdf) (reporting participation in various psychiatric services by recipients of court-ordered treatment).

<sup>5</sup> See Jennifer Honig & Susan Stefan, *New Research Continues to Challenge the Need for Outpatient Commitment*, 31 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 109, 110 (2005) (defining types of outpatient commitment). Thirteen states have more lenient criteria for IOC than for inpatient commitment. See TREATMENT ADVOC. CENTER, *ASSISTED PSYCHIATRIC TREATMENT INPATIENT AND OUTPATIENT STANDARDS BY STATE* (2011), available at [http://www.treatmentadvocacycenter.org/storage/documents/State\\_Standards\\_-\\_The\\_Chart-June\\_28\\_2011.pdf](http://www.treatmentadvocacycenter.org/storage/documents/State_Standards_-_The_Chart-June_28_2011.pdf) (compiling inpatient and outpatient commitment standards by state).

people from reaching the point of requiring hospitalization.<sup>6</sup> These statutes “widen the net” of the state mental health system by allowing that system to supervise people with a severe mental illness who are not currently subject to involuntary hospitalization.<sup>7</sup> Furthermore, these statutes intend to protect the public from violence committed by people with an untreated mental illness.<sup>8</sup> They also aim to improve public health by providing treatment to mentally ill people before their condition becomes severe enough to require hospitalization.<sup>9</sup>

This Note discusses IOC statutes from the perspective of mentally ill clients and their attorneys. IOC statutes, especially those including preventative IOC, are often passed after a highly-publicized violent crime committed by a mentally ill person, and advocates of the laws defend them based on the risk of violence they argue mentally ill individuals pose to the community.<sup>10</sup> The methods used to compel treatment for violent, mentally ill individuals are then applied to nonviolent, mentally ill individuals.<sup>11</sup> Although nonviolent, mentally ill people may require some form of community-based care to prevent homelessness or institutionalization, this Note argues that applying a standard to all mentally ill people that assumes

---

<sup>6</sup> See Honig & Stefan, *supra* note 5, at 110 (defining types of outpatient commitment); see also FLA. STAT. ANN. § 394.4655 (West 2011); MICH. COMP. LAWS ANN. § 330.1401(401)(1)(d) (West Supp. 2011) (detailing examples of preventative IOC statutes); MENTAL HYG. LAW § 9.60.

<sup>7</sup> See, e.g., WELF. & INST. CODE §§ 5345-5349.5; MENTAL HYG. LAW § 9.60; N.C. GEN. STAT. § 122C-271; see also Erin O'Connor, Note, *Is Kendra's Law a Keeper? How Kendra's Law Erodes Fundamental Rights of the Mentally Ill*, 11 J.L. & POL'Y 313, 321-23 (2002) (describing preventative outpatient commitment for individuals who do not meet standard for inpatient hospitalization).

<sup>8</sup> See Rachel A. Scherer, Note, *Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventive Outpatient Treatment*, 4 IND. HEALTH L. REV. 361, 385 (2007) (describing publicized crimes which preceded enactment of New York's and California's IOC statutes).

<sup>9</sup> See *id.* at 371 (suggesting preventative IOC reduces “homelessness, recidivism, incidences of harmful behaviors, and victimization”).

<sup>10</sup> See *id.* at 385 (describing killings precipitating Kendra's Law and Laura's Law); see also *Assisted Outpatient Treatment Laws*, *supra* note 3 (advocating IOC to reduce “violent episodes” among mentally ill people). But see Henry J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES GEN. PSYCHIATRY 393, 393 (1998) (stating mentally ill people not significantly more violent than controls).

<sup>11</sup> See Henry A. Dlugacz, *Involuntary Outpatient Commitment: Some Thoughts on Promoting a Meaningful Dialogue Between Mental Health Advocates and Lawmakers*, 53 N.Y.L. SCH. L. REV. 79, 85-87 (2008-2009) (discussing effect of media coverage on public view of mental illness). The perception that mentally ill people are prone to violence allows IOC statutes to be used for “monitoring and treatment” rather than to promote individual well-being, even when the individual in question has no history of violence. *Id.* at 87; see also Honig & Stefan, *supra* note 5, at 112-13 (disputing claim that IOC is required to “contain” mentally ill individuals).

a risk of violence fails to serve their needs.<sup>12</sup> To uphold individual autonomy rights as much as possible in the face of IOC statutes, advocates for mentally ill individuals must be guided by the client's objectives and attempt to achieve an outcome that will be acceptable to that client.<sup>13</sup>

Part II of this Note examines involuntary outpatient commitment statutes, with an emphasis on preventative IOC.<sup>14</sup> Part III begins with a brief examination of the history of involuntary commitment and treatment.<sup>15</sup> Part III then explores the constitutional issues surrounding IOC.<sup>16</sup> Next, Part IV-A addresses some of the reported benefits of IOC statutes as well as the concerns surrounding their use.<sup>17</sup> Finally, Part IV-B analyzes how IOC statutes can be used to obtain the necessary services for mentally ill clients, and addresses remaining concerns about effectiveness and patient autonomy.<sup>18</sup>

---

<sup>12</sup> See Honig & Stefan, *supra* note 5, at 119-120 (calling for community-based voluntary treatment as alternative to IOC); NAT'L COUNCIL ON DISABILITY, FROM PRIVILEGES TO RIGHTS: PEOPLE LABELED WITH PSYCHIATRIC DISABILITIES SPEAK FOR THEMSELVES 6-8 (2000), available at [http://www.ncd.gov/rawmedia\\_repository/21553992\\_2d13\\_4dcb\\_a1c4\\_ee6c9e9434e8?document.pdf](http://www.ncd.gov/rawmedia_repository/21553992_2d13_4dcb_a1c4_ee6c9e9434e8?document.pdf) (calling for voluntary mental health system including variety of social services). The National Council on Disability expressed concern that funding for IOC programs will take money from already underfunded voluntary treatment programs. *Id.* at 12; see also Michael Allen & Vicki Fox Smith, *Opening Pandora's Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 342, 344 (2001) (expressing concern that threat of court-ordered medication will deter patients from seeking treatment); Bruce J. Winick et al., *Endorsement of Personal Benefit of Outpatient Commitment Among Persons with Severe Mental Illness*, 9 PSYCHOL. PUB. POL'Y & L. 70, 87 (2003) (finding majority of patients held negative view of IOC both before and after treatment).

<sup>13</sup> See Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework*, 84 YALE L.J. 1540, 1542-43 (1975) [hereinafter *Yale Note*] (discussing role of advocate in civil commitment proceeding). While some attorneys believe that their role in mental health proceedings is to act as a zealous advocate for their clients, others take the paternalistic approach of attempting to act in the client's best interests, regardless of the client's input. See Janet B. Abisch, *Mediational Lawyering in the Civil Commitment Context: A Therapeutic Jurisprudence Solution to the Counsel Role Dilemma*, 1 PSYCHOL. PUB. POL'Y & L. 120, 121-22 (1995) (discussing adversarial and best-interests approaches). However, the Model Rules of Professional Responsibility state that an attorney should, as much as possible, maintain a normal attorney-client relationship when dealing with a mentally incapacitated client. MODEL RULES OF PROF'L CONDUCT R. 1.14(a) (2009). When appropriate, the attorney can use mediation techniques to attempt to achieve a result amenable to the client. Henry Chen, *Current Development, The Mediation Approach: Representing Clients with Mental Illness in Civil Commitment Proceedings*, 19 GEO. J. LEGAL ETHICS 599, 610-11 (2006) (discussing use of mediation in mental health proceedings).

<sup>14</sup> See *infra* Part II (examining various outpatient commitment statutes).

<sup>15</sup> See *infra* Part III (discussing limitations on involuntary treatment).

<sup>16</sup> See *infra* Part III (exploring right to refuse treatment in IOC context).

<sup>17</sup> See *infra* Part IV-A (discussing effect of IOC on patients).

<sup>18</sup> See *infra* Part IV-B (analyzing best uses of IOC along with remaining concerns).

## II. FACTS

### *A. Background on Involuntary Outpatient Commitment*

The earliest outpatient commitment statutes were passed in the 1950s after government and public opinion began to turn away from the large-scale institutionalization of mentally ill people.<sup>19</sup> The introduction of antipsychotic medication to treat the positive symptoms of psychosis, such as delusions and hallucinations, also aided the shift toward outpatient treatment.<sup>20</sup> These early laws acted as a form of conditional release for people who were institutionalized but found to be capable of living in the community with supervision and treatment.<sup>21</sup> Outpatient commitment also acted as the least restrictive alternative for individuals who met the already-existing standard for involuntary commitment as an inpatient.<sup>22</sup> Both of these models use the same legal standard for IOC as they do for inpatient commitment, meaning that only someone who would otherwise need hospitalization was subject to court-ordered treatment.<sup>23</sup>

In recent years, another form of IOC has developed, known as preventative outpatient commitment.<sup>24</sup> Unlike other forms of outpatient commitment, these laws seek to bring into the state mental health system those persons who would not otherwise have been subject to involuntary commitment.<sup>25</sup> Generally, preventative IOC statutes are enacted with the hope of preventing future dangerousness among mentally ill people who

---

<sup>19</sup> See Worthington, *supra* note 2, at 216-17 (describing shift from institutionalization to less restrictive environments).

<sup>20</sup> See Strang, *supra* note 2, at 250-51 (describing introduction of Thorazine to treat psychosis).

<sup>21</sup> See N.C. GEN. STAT. § 122C-263 (2011) (describing criteria for outpatient commitment); see also Bruce J. Winick et al., *Therapeutic Jurisprudence and Outpatient Commitment Law: Kendra's Law as Case Study*, 9 PSYCHOL. PUB. POL'Y & L. 183, 187-88 (2003) (outlining early outpatient laws via "paradigmatic" North Carolina statute).

<sup>22</sup> See MICHAEL L. PERLIN, THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL 80-82 (American Psychological Association 2000) (describing use of outpatient commitment as least restrictive alternative); Jessica L. MacKeigan, Note, *Violence, Fear, and Jason's Law: The Needless Expansion of Social Control over the Non-Dangerous Mentally Ill in Ohio*, 56 CLEV. ST. L. REV. 739, 744-45 (2008) (discussing various forms of outpatient commitment). This standard generally requires clear and convincing evidence that the person is a danger to themselves or others, or that they are gravely disabled to the extent that they are unable to provide for their own basic needs. See Scherer, *supra* note 8, at 366.

<sup>23</sup> See PERLIN, *supra* note 22, at 80-82 (differentiating conditional release and least restrictive treatment from preventative outpatient commitment).

<sup>24</sup> See Scherer, *supra* note 8, at 362 (introducing concept of preventative IOC).

<sup>25</sup> See MacKeigan, *supra* note 22, at 745 (stating rationale for preventative outpatient commitment); see also Scherer, *supra* note 8, at 382-84 (laying out ideal use of preventative IOC through hypothetical example).

are not deemed dangerous by clear and convincing evidence.<sup>26</sup> These statutes also aim to prevent mental illness from deteriorating to the point when the individual requires hospitalization, by providing treatment to the person before he or she reaches that point of commitment under traditional standards.<sup>27</sup> In this way, preventative IOC can work as a device to bring scarce mental health resources to those in the community who need it most.<sup>28</sup> However, the laws also subject a larger group of people to coerced mental health treatment, thus creating concerns involving civil liberties.<sup>29</sup>

### *B. Kendra's Law*

The paradigmatic preventative IOC statute is New York's Kendra's Law.<sup>30</sup> Kendra's Law was passed in 1999 following a publicized incident in which a mentally ill man, Andrew Goldstein, killed a woman by pushing her into the path of an oncoming train.<sup>31</sup> Doctors had previously diagnosed Mr. Goldstein with schizophrenia, and he had sought treatment in the community; however, he had been refused due to insufficient resources.<sup>32</sup>

---

<sup>26</sup> See Kendra's Law, ch. 408, § 2, 1999 N.Y. Laws 2091 ("The legislature finds that there are mentally ill persons who are capable of living in the community . . . but who, without routine care and treatment, may relapse and become violent or suicidal . . ."); see also Emily S. Huggins, Note, *Assisted Outpatient Treatment: An Unconstitutional Invasion of Protected Rights or a Necessary Government Safeguard?*, 30 J. LEGIS. 305, 305 (2004) (describing death of Kendra Webdale and subsequent enactment of Kendra's Law); *Sad But True—Tragedies Raise Visibility*, TREATMENT ADVOC. CENTER, [http://www.treatmentadvocacycenter.org/index.php?option=com\\_content&task=view&id=1720&Itemid=97](http://www.treatmentadvocacycenter.org/index.php?option=com_content&task=view&id=1720&Itemid=97) (last visited Apr. 20, 2012) (expressing hope that Gabrielle Giffords's shooting will result in broader involuntary treatment standards). Some studies have found that IOC had the effect of preventing later criminal conduct. See Marvin S. Swartz et al., *A Randomized Controlled Trial of Outpatient Commitment in North Carolina*, 52 PSYCHIATRIC SERVICES 325, 327 (2001) (showing effect of IOC on violence); Henry J. Steadman et al., *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*, 52 PSYCHIATRIC SERVICES 330, 333 (2001) (showing reduced incidence of arrest among IOC patients). But see Dlugacz, *supra* note 11, at 85-87 (suggesting media frenzy over violence prevention obscures efforts to address needs of mentally ill people).

<sup>27</sup> See E. Fuller Torrey & Mary Zdanowicz, *Outpatient Commitment: What, Why and for Whom* 52 PSYCHIATRIC SERVICES 337, 337 (2001) (suggesting IOC necessary because mentally ill people lack awareness of their illness); see also Scherer, *supra* note 8, at 367 (suggesting preventative IOC improves social welfare by providing treatment to nonviolent mentally ill people).

<sup>28</sup> See Worthington, *supra* note 2, at 238-39 (suggesting Kendra's Law allows New York to "concentrat[e] resources on the most needy").

<sup>29</sup> See Winick et al., *supra* note 21, at 200-01 (questioning how Kendra's Law impacts patient's right to refuse medication).

<sup>30</sup> See N.Y. MENTAL HYG. LAW § 9.60 (Consol. Supp. 2012).

<sup>31</sup> See FINAL REPORT, *supra* note 4, at 1 (describing circumstances of passing law).

<sup>32</sup> See Dlugacz, *supra* note 11, at 80 & n.3 (providing further description of circumstances of killing).

Kendra's Law allows the court to order any individual meeting its requirements to comply with case management and a treatment plan that commonly involves medication.<sup>33</sup>

Individuals are subject to court-mandated treatment under Kendra's Law if they meet seven eligibility requirements.<sup>34</sup> These requirements include that the person must be eighteen years of age or older and be diagnosed with a mental illness.<sup>35</sup> He or she must be "unlikely to survive safely in the community without supervision," as determined by the interviewing psychiatrist.<sup>36</sup> He or she must have a history of lack of compliance with treatment, which has resulted either in two or more hospitalizations within the last thirty-six months, or in one or more acts or threats of violence within the past forty-eight months.<sup>37</sup> He or she must be "unlikely to voluntarily participate in outpatient treatment."<sup>38</sup> Finally, the person must be in need of outpatient treatment to prevent a "relapse or deterioration," and must be likely to benefit from outpatient treatment.<sup>39</sup> However, no finding of incompetency to make treatment decisions is necessary to subject a person to a court order, and a Kendra's Law order is explicitly prohibited from being used to determine incompetency.<sup>40</sup>

Any of a variety of parties can file a petition to initiate proceedings under Kendra's Law, including anyone living with the mentally ill person, an immediate family member of the mentally ill person, or a treating psychiatrist or psychologist.<sup>41</sup> Additionally, the petition must be accompanied by an affidavit of a physician who has examined the person or has been unable to complete the examination due to lack of cooperation.<sup>42</sup> After the court receives the petition, it must conduct a hearing within three days.<sup>43</sup> If the person who is the subject of the petition fails to attend the hearing, the court may conduct the hearing and issue the

---

<sup>33</sup> See MENTAL HYG. LAW § 9.60(a)(1) (requiring case management and providing variety of possible treatment services).

<sup>34</sup> *Id.* § 9.60(c)(1)-(7).

<sup>35</sup> *Id.* § 9.60(c)(1)-(2).

<sup>36</sup> *Id.* § 9.60(c)(3). The use of the word "unlikely" provides little objective meaning, giving the interviewing psychiatrist great latitude to decide whether or not the criterion is met. See Jennifer Gutterman, Note, *Waging a War on Drugs: Administering a Lethal Dose to Kendra's Law*, 68 FORDHAM L. REV. 2401, 2437 (2000) (analyzing implications of "unlikely").

<sup>37</sup> MENTAL HYG. LAW § 9.60(c)(4)(i)-(ii).

<sup>38</sup> *Id.* § 9.60(c)(5).

<sup>39</sup> *Id.* § 9.60(c)(6)-(7).

<sup>40</sup> *Id.* § 9.60(o); see also Gutterman, *supra* note 36, at 2414 (asserting controversy over lack of incompetency requirement).

<sup>41</sup> See MENTAL HYG. LAW § 9.60(e)(1)(i)-(viii).

<sup>42</sup> *Id.* § 9.60(e)(3)(i)-(ii).

<sup>43</sup> *Id.* § 9.60(h)(1).

order in the subject's absence.<sup>44</sup> Finally, the statute grants the person who is the subject of the petition a right to counsel.<sup>45</sup>

If the court determines that the person meets the criteria for IOC, it issues an order mandating compliance with the examining physician's written treatment plan.<sup>46</sup> The subject of the petition and his or her treating physician must be given the opportunity to participate in the process of creating the treatment plan.<sup>47</sup> The court does not have the authority to order treatment that deviates from the written plan.<sup>48</sup> The initial order lasts for six months, and can be extended for periods of one year at a time.<sup>49</sup> A person who violates the order, for example, by declining to take medication as ordered in the treatment plan, can be removed to a hospital and detained for up to seventy-two hours for observation.<sup>50</sup> Any longer period of detention must comply with standard involuntary commitment procedures, and non-compliance with the order is not itself grounds for commitment.<sup>51</sup>

### C. Other Preventative IOC Statutes

The first state to enact a preventative outpatient commitment statute was North Carolina in 1983.<sup>52</sup> North Carolina's statute allows any person to appear before a magistrate and petition the court to take a mentally ill individual into custody for examination.<sup>53</sup> For such an order to issue, the court must find that the mentally ill individual is dangerous to others, dangerous to himself or herself, or requires treatment to prevent "deterioration that would predictably result in dangerousness."<sup>54</sup> The examining physician may recommend inpatient or outpatient treatment; if

<sup>44</sup> *Id.* The ability to conduct ex parte hearings raises concerns about the ability of certain people to defend their rights in court, such as homeless people, who may be difficult to serve with process within the three day period. See Winick et al., *supra* note 21, at 197-98 (discussing implications of hearings in absentia).

<sup>45</sup> MENTAL HYG. LAW § 9.60(g).

<sup>46</sup> *Id.* § 9.60(i).

<sup>47</sup> *Id.* The law also allows the subject of the petition to include a significant person, such as a relative or close friend, in the proceedings. *Id.*

<sup>48</sup> *Id.*

<sup>49</sup> *Id.* § 9.60(j)(2), (k).

<sup>50</sup> N.Y. MENTAL HYG. LAW § 9.60(n) (Consol. Supp. 2012).

<sup>51</sup> *Id.*; see also *In re K.L.*, 806 N.E.2d 480, 485 (N.Y. 2004) ("[T]he coercive force of the order lies solely in the compulsion generally felt by law-abiding citizens to comply with court directives."); *infra* Part III (describing how court held Kendra's Law not to constitute forced medication).

<sup>52</sup> See Winick et al., *supra* note 21, at 187-88 (describing North Carolina law as "paradigmatic" outpatient commitment statute); see also N.C. GEN. STAT. § 122C-271 (2011).

<sup>53</sup> § 122C-261.

<sup>54</sup> *Id.*



outpatient treatment is recommended, the court must hold a hearing to determine whether the individual will be subject to IOC.<sup>55</sup> For the court to order IOC, the subject must be mentally ill, capable of surviving safely in the community with supervision, in need of treatment to prevent deterioration that would result in dangerousness, and the individual's mental illness must limit his or her ability to accept voluntary treatment.<sup>56</sup> Because the person subjected to the petition is taken into custody, North Carolina's law allows a more immediate intrusion into a subject's civil liberty interests than Kendra's Law; however, because the criteria require dangerousness rather than merely "deterioration," it ultimately covers a more limited group of people.<sup>57</sup>

In contrast, California's IOC statute, known as Laura's Law and enacted in 2002, is largely based on Kendra's Law.<sup>58</sup> The statute includes the seven eligibility criteria set out in Kendra's Law and adds two additional criteria: first, the person's condition must be "substantially deteriorating," and, second, the IOC must be the least restrictive placement necessary for the person.<sup>59</sup> In addition, only the county mental health director may file a petition.<sup>60</sup> Counties enact Laura's Law on an opt-in basis, and each adopting county must provide on its own the required funding.<sup>61</sup>

---

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> See *id.* § 122C-263(d) (stating determinations on which commitment is based); Strang, *supra* note 2, at 261-62 (outlining requirements for North Carolina IOC statute); cf. N.Y. MENTAL HYG. LAW § 9.60(c)(6) (Consol. Supp. 2012) (stating individual must need IOC "in order to prevent a relapse or deterioration").

<sup>58</sup> See CAL. WELF. & INST. CODE §§ 5345-5349.5 (West 2010); MENTAL HYG. LAW § 9.60; see also Scherer, *supra* note 8, at 393 (describing derivation of Laura's Law from Kendra's Law). California passed Laura's Law after Scott Thorpe, a man with delusional paranoia, killed Laura Wilcox. See Editorial, *Carry Out "Laura's Law,"* S.F. CHRON., Mar. 21, 2006, at B6.

<sup>59</sup> WELF. & INST. CODE § 5346(a)(6)-(7).

<sup>60</sup> *Id.* § 5346(b)(1). Individuals who would be able to file a petition under Kendra's Law are instead allowed to request a petition under Laura's Law. *Id.* § 5346(b)(2).

<sup>61</sup> See Scherer, *supra* note 8, at 419 (outlining opt-in system for Laura's Law). Perhaps due to funding problems, only Los Angeles County has attempted to adopt Laura's Law. See *id.* at 421-22. However, Los Angeles County did not adopt the full provisions of the law, but instead enacted a limited pilot program for people already in the criminal justice system. *Id.* at 422; see also *In re Arden Hill Hosp.*, 703 N.Y.S.2d 902, 906 (Sup. Ct. 2000) (holding county bears cost of outpatient commitment under Kendra's Law).

## III. HISTORY

*A. Background*

The state may compel the treatment of mentally ill individuals under the principle of *parens patriae* and the state's police powers.<sup>62</sup> The police power interest allows a state to provide involuntary treatment—such as commitment to a mental hospital—when it is necessary to protect the safety of the public.<sup>63</sup> However, justifying forced treatment under the police power requires, at a minimum, that the subject be dangerous.<sup>64</sup> *Parens patriae* allows the state to act in the best interests of a person who is unable to make decisions on his or her own behalf.<sup>65</sup> Therefore, a finding of incompetency is generally necessary in order for *parens patriae* to be invoked.<sup>66</sup> In most jurisdictions, even a person who meets the standard for involuntary commitment as an inpatient is presumed to be competent to make treatment decisions.<sup>67</sup> The state interest in involuntary outpatient commitment is near the edges of the two spheres of either the police power or the *parens patriae* interest.<sup>68</sup> However, because the United States

---

<sup>62</sup> See Dennis E. Cichon, *The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L. REV. 283, 336-38 (1992) (identifying sources of government power); MacKeigan, *supra* note 22, at 744 (outlining uses of state's police power and *parens patriae* interests).

<sup>63</sup> See Cichon, *supra* note 62, at 337-39 (describing foundation of police power interest in involuntary treatment). This interest includes preventing a mentally ill person from harming him- or herself. *Id.*

<sup>64</sup> See *id.* (justifying forced treatment to prevent harm to individual or community); see also *Davis v. Hubbard*, 506 F. Supp. 915, 935 (N.D. Ohio 1980) (holding forced medication under police power requires that patient is "presently violent or self-destructive"); *In re Orr*, 531 N.E.2d 64, 73 (Ill. App. Ct. 1988) (holding individual may refuse treatment unless immediate threat of harm to self or others); *Rogers v. Comm'r of Dep't of Mental Health*, 458 N.E.2d 308, 323 (Mass. 1983) ("In a nonemergency situation, no State interest is sufficiently compelling to overcome a patient's decision to refuse treatment with antipsychotic drugs.").

<sup>65</sup> See MacKeigan, *supra* note 22, at 744 (outlining state police power).

<sup>66</sup> See Cichon, *supra* note 62, at 345 (setting out requirement for invocation of *parens patriae* authority).

<sup>67</sup> See *Rogers*, 458 N.E.2d at 314 (stating committed patient must be found incompetent by judge to force medication); *Jarvis v. Levine*, 418 N.W.2d 139, 148-49 & n.7 (Minn. 1988) (holding separate finding of incompetency must be made before forced medication of committed patient); see also Cichon, *supra* note 62, at 350 n.435 (citing numerous cases suggesting committed patient not necessarily incompetent).

<sup>68</sup> See MacKeigan, *supra* note 22, at 755-56 (examining state interest in proposed Ohio IOC statute). The state's police power is tenuous because preventative IOC deals with only those people who are not currently dangerous but at most may become dangerous in the future. See Huggins, *supra* note 26, at 320 (arguing Kendra's Law is "preventive measure" not within police power). The *parens patriae* justification is similarly weak because preventative IOC does not require a finding of incompetence. See Gutterman, *supra* note 36, at 2436-37 (suggesting

Supreme Court has done little to specify what due process protections should be afforded in the mental health context, the practical extent of those interests is largely left to each individual state to determine.<sup>69</sup>

In *Washington v. Harper*,<sup>70</sup> the Court found that an individual has a constitutionally protected liberty interest in avoiding involuntary psychiatric medication.<sup>71</sup> However, this right is not absolute, and the procedural protections required to protect the right vary by context according to the government interest implicated by the person's refusal.<sup>72</sup> Although the decision in *Harper* upheld the prison policies in question, the court indicated that stronger procedural protections were required outside of the prison context.<sup>73</sup>

Somewhat more relevant is the Court's decision in *Riggins v. Nevada*.<sup>74</sup> *Riggins* involved the right of a pre-trial detainee to refuse medication during the period of trial.<sup>75</sup> Though the Court did not establish a specific standard for states to follow in providing due process, it suggested that, if the treatment was "medically appropriate and, considering less intrusive alternatives, essential for [petitioner's] own safety or the safety of others," it would meet due process standards.<sup>76</sup> Individuals outside the criminal context are entitled to at least the due process protections retained by pre-trial detainees.<sup>77</sup>

---

Kendra's Law is outside of *parens patriae* because no finding of incompetence required).

<sup>69</sup> See Gutterman, *supra* note 36, at 2418 (explaining varying extent of due process rights by state); see also *infra* notes 70-76 and accompanying text (outlining Supreme Court decisions on involuntary medication).

<sup>70</sup> 494 U.S. 210 (1990).

<sup>71</sup> *Id.* at 221-22 ("[R]espondent possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.").

<sup>72</sup> See *id.* at 226 (describing context for refusal of medication). The respondent in *Harper* was a prisoner, and the Court determined that in the prison context, review by a second psychiatrist sufficiently protected the respondent's due process interest. *Id.* at 222-23. Because of the strength and legitimacy of the state's interest in prison regulation, the Court reviews due process protections of prisoners' constitutional rights at a more lenient standard than outside the prison context. *Id.* at 223. Therefore, the substance of the *Harper* ruling on procedural due process is unlikely to apply outside the prison system. See *id.*

<sup>73</sup> See *id.* at 223 ("[T]he State under other circumstances would have been required to satisfy a more rigorous standard of review."); see also Cichon, *supra* note 62, at 416-17 (analyzing *Harper* as applied to right to refuse medication among general population).

<sup>74</sup> 504 U.S. 127 (1992).

<sup>75</sup> *Id.* at 129-31. The petitioner did not need the medication to be competent to stand trial. *Id.* at 130. The Court found that the due process protection, review of the prescription by three court-ordered physicians, was not sufficient to protect the petitioner's interest in refusing the drugs. *Id.* at 129.

<sup>76</sup> *Id.* at 135.

<sup>77</sup> See Cichon, *supra* note 62, at 419-20 (suggesting three-tier system for due process right to

States can provide for a higher level of due process protections within their own mental health system.<sup>78</sup> For example, in *Rivers v. Katz*,<sup>79</sup> the New York Court of Appeals held that under the state constitution, the ability of an institutionalized person to refuse medication was a fundamental right.<sup>80</sup> In order for the state's police power to justify forced medication, there must be an emergency which creates a compelling state interest, and medication is justified only for the duration of the emergency.<sup>81</sup> Forced medication under a state's *parens patriae* interest is justified only by a finding that the person is incompetent to make his or her own treatment decisions.<sup>82</sup> Without a finding of incompetency, however, the *parens patriae* interest cannot apply—the state has no interest in substituting its treatment decisions for those of a competent person.<sup>83</sup>

### B. Decisions on Involuntary Outpatient Commitment

New York courts have consistently upheld the constitutionality of Kendra's Law, despite the protections provided in *Rivers*.<sup>84</sup> The first challenge to Kendra's Law asserted due process and equal protection violations, arguing that under *Rivers*, the law required a finding of incapacity to subject a patient to outpatient commitment.<sup>85</sup> The court held

drug refusal); see also *Harper*, 494 U.S. at 223 (stating civil setting required “more rigorous” review).

<sup>78</sup> See *Rogers v. Comm'r of Dep't of Mental Health*, 458 N.E.2d 308, 314 (Mass. 1983) (finding no state interest sufficient to force medication outside of emergency); *Rivers v. Katz*, 495 N.E.2d 337, 341 (N.Y. 1986) (finding right to refuse medication fundamental under New York State Constitution);

<sup>79</sup> 495 N.E.2d 337 (N.Y. 1986).

<sup>80</sup> *Rivers*, 495 N.E.2d at 344 (holding that right to refuse is fundamental).

<sup>81</sup> See *id.* at 342-43 (suggesting level of immediate dangerousness required to create compelling state interest).

<sup>82</sup> See *id.* at 343 (setting out level of review required to invoke *parens patriae* interest). A finding of incompetency must be proved by clear and convincing evidence at a separate judicial hearing. *Id.* at 344. An individual is not incompetent by virtue of being mentally ill or institutionalized. *Id.*; see also Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 LAW & HUM. BEHAV. 149, 169 (1995) (finding mentally ill people made decisions with similar competence to people without mental illness).

<sup>83</sup> See *Rivers*, 495 N.E.2d at 343 (emphasizing grounds behind *parens patriae* interest).

<sup>84</sup> See *In re K.L.*, 806 N.E.2d 480, 484 (N.Y. 2004) (holding incompetency not required because law does not authorize forced medication); *In re Urcuyo*, 714 N.Y.S.2d 862, 873 (N.Y. Sup. Ct. 2000) (holding no finding of incompetency necessary for IOC order); see also *Rivers*, 495 N.E.2d at 344 (stating fundamental right to refuse medication).

<sup>85</sup> See *In re Urcuyo*, 714 N.Y.S.2d at 865 (setting out plaintiffs' constitutional claims); see also *Rogers v. Okin*, 634 F.2d 650, 657 (1st Cir. 1980) (“[T]he individual himself must be incapable of making a competent decision concerning treatment [for state to force medication under *parens patriae*].”).

that Kendra's Law was not subject to a *Rivers* analysis because a court-ordered treatment plan involving medication did not constitute forced medication.<sup>86</sup> It reasoned that because the law requires a person to have the opportunity to participate in creating their own treatment plan, the legislature anticipated that the law applied only to people competent to make treatment decisions.<sup>87</sup> The court also rejected the plaintiffs' additional arguments on summary arrest and equal protection.<sup>88</sup>

In *In re K.L.*,<sup>89</sup> the New York Court of Appeals again declared that Kendra's Law did not violate any constitutional interest.<sup>90</sup> The respondent was under a Kendra's Law order requiring him to self-administer antipsychotics, or otherwise submit to intravenous administration.<sup>91</sup> Similarly, this respondent argued that Kendra's Law required a judicial finding of incompetency in order to comply with constitutional requirements.<sup>92</sup> Again, the New York Court of Appeals held that *Rivers* did not apply to Kendra's Law because the law "does not permit forced medical treatment."<sup>93</sup> The *In re K.L.* court suggested that the state's police power interest is more compelling when individuals are in the community, because they present a greater danger if they were to become violent than people under inpatient commitment.<sup>94</sup> In addition, the court claimed that

---

<sup>86</sup> See *In re Urcuyo*, 714 N.Y.S.2d at 868-69 (justifying court-ordered medication for outpatients as not forced).

<sup>87</sup> See *id.* at 868 (inferring legislative intent that Kendra's Law apply to competent individuals). The court surmised that the judge would not grant an IOC order if the individual had not had the opportunity to meaningfully participate in the treatment plan. *Id.*

<sup>88</sup> See *id.* at 873 (holding Kendra's Law constitutional). The seventy-two hour evaluation period for non-compliant individuals did not constitute "summary arrest," as argued by the plaintiffs, but rather, arose from the state's compelling interest in ensuring that the individual, while not medicated, did not need involuntary commitment. *Id.* at 868. If the individual were placed in inpatient commitment, *Rivers* would protect them against forced medication. See *Worthington*, *supra* note 2, at 231 (analyzing constitutional consequences of seventy-two hour detention). The court similarly rejected the equal protection challenge on grounds that because the court order did not constitute forced medication, the state did not violate a fundamental right of the subject. *In re Urcuyo*, 714 N.Y.S.2d at 872-73.

<sup>89</sup> 806 N.E.2d 480 (N.Y. 2004).

<sup>90</sup> *Id.* at 486 (holding IOC proceedings under Kendra's Law satisfy due process).

<sup>91</sup> *Id.* at 482 (setting out facts of case). The respondent had schizoaffective disorder, bipolar type, and a history of hospitalization. *Id.* In addition to medication, the treatment order required him to undergo case management, therapy, and blood testing. *Id.*

<sup>92</sup> See *id.* at 483-84 (stating respondent's constitutional claims).

<sup>93</sup> *Id.* at 484. The court relied on the lack of coercive punishment available for those who fail to comply with a Kendra's Law order. See *id.* at 485 ("[T]he coercive force of the order lies solely in the compulsion generally felt by law-abiding citizens to comply with court directives."). Kendra's Law does not allow a person to be held in contempt for failing to comply with the court order, nor can that person be subject to involuntary commitment on those grounds. N.Y. MENTAL HYG. LAW § 9.60(n) (Consol. Supp. 2012).

<sup>94</sup> See *In re K.L.*, 806 N.E.2d at 485-86 (suggesting heightened state police power interest in

the state has a *parens patriae* interest in treating an individual person to a Kendra's Law order because those subject to the law's purview are "unlikely to survive safely in the community" without treatment.<sup>95</sup>

Although Kendra's Law appears for the moment to be firmly in place in New York, preventative IOC has been successfully challenged elsewhere.<sup>96</sup> In *Protection and Advocacy System v. City of Albuquerque*,<sup>97</sup> the New Mexico Court of Appeals struck down a city ordinance modeled after Kendra's Law.<sup>98</sup> While the court did not decide the case on due process grounds, it nevertheless struck the law down, finding that the state mental health code preempted the ordinance, which stated that "[n]o psychotropic medication . . . shall be administered to any client without proper consent."<sup>99</sup> Unlike in *In re K.L.*, the court held that a court order issued under the ordinance constituted the administration of medication without consent.<sup>100</sup> In fact, the court specifically declined to harmonize its reasoning with that of *In re K.L.*, stating that "the coercive nature of a court order requiring treatment would clearly allow an act contrary to the statute's mandate that an individual's consent be obtained."<sup>101</sup> Although *In re K.L.* remains a strong sanction for Kendra's Law, not all jurisdictions agree that court-ordered medication does not constitute involuntary treatment.<sup>102</sup>

---

individuals outside of institutions); see also Scherer, *supra* note 8, at 405 (arguing individuals in community subject to reduced due process scrutiny). Scherer suggests that once "the state has proven by clear and convincing evidence that the individual is severely mentally ill," the burden should shift to the individual to show that the treatment is not related to a legitimate state interest. *Id.* But see Gutterman, *supra* note 36, at 2422 (suggesting individuals in community not deemed dangerous or incompetent should receive heightened standard of review).

<sup>95</sup> See *In re K.L.*, 806 N.E.2d at 486 (asserting *parens patriae* interest in treating patients under Kendra's Law). This expanded state interest appears to lower the standard required in *Rivers*, which stated explicitly that the state has no *parens patriae* interest in making treatment decisions for a competent individual. See *Rivers v. Katz*, 495 N.E.2d 337, 343 (N.Y. 1986) (stating grounds for *parens patriae* interest in taking care of people unable to make decisions). As in *In re Urcuyo*, the court in *In re K.L.* found that the seventy-two-hour detention was justified by a compelling state interest in monitoring a mentally ill person with a potentially deteriorating condition. *In re K.L.*, 806 N.E.2d at 487; *In re Urcuyo*, 714 N.Y.S.2d 862, 873 (Sup. Ct. 2000).

<sup>96</sup> See *Prot. & Advocacy Sys. v. City of Albuquerque*, 195 P.3d 1, 4 (N.M. Ct. App. 2008) (affirming permanent injunction against ordinance).

<sup>97</sup> 195 P.3d 1 (N.M. Ct. App. 2008).

<sup>98</sup> *Id.* at 4-7 (detailing provisions of ordinance).

<sup>99</sup> See *id.* at 18, 20 (holding informed consent provision in state mental health code preempted ordinance).

<sup>100</sup> See *id.* at 19-20 (analyzing ordinance for preemption).

<sup>101</sup> *Id.* at 21.

<sup>102</sup> See *Prot. & Advocacy Sys.*, 195 P.3d at 20 (finding court-ordered compliance with treatment plan constitutes medicating without consent).

#### IV-A. POLICY ISSUES SURROUNDING INVOLUNTARY OUTPATIENT COMMITMENT

Supporters of IOC commonly refer to the statutes' ability to prevent violence.<sup>103</sup> Preventative IOC statutes are often passed after a mentally ill person has committed a high-profile violent crime as a bid to prevent further violence.<sup>104</sup> One study of the North Carolina outpatient commitment program found that long-term IOC reduced the incidence of further violence in patients who had an existing history of violence.<sup>105</sup> Although the New York State report on Kendra's Law did not specifically track violent acts, it did report major decreases in the incidence of arrest and incarceration among IOC recipients.<sup>106</sup>

While this framing technique is effective at rallying public support for preventative IOC laws, relying on media portrayals of dangerous psychotics committing random acts of violence confuses the issues surrounding access to effective treatment and the autonomy of mentally ill individuals.<sup>107</sup> Contrary to widespread public perception, clinical research shows that mentally ill people are not more likely to commit acts of

---

<sup>103</sup> See Huggins, *supra* note 26, at 305 ("Kendra Webdale never saw it coming."); Scherer, *supra* note 8, at 367 (suggesting Virginia Tech massacre caused by lack of coercive treatment).

<sup>104</sup> See Dlugacz, *supra* note 11, at 85 (suggesting relationship between media portrayals of dangerousness and enactment of Kendra's Law). The New York Legislature passed Kendra's Law in a "media frenzy" after Andrew Goldstein, a man with untreated schizophrenia, pushed Kendra Webdale in front of a subway train, resulting in her death. Worthington, *supra* note 2, at 221. California passed Laura's Law after Scott Thorpe, a patient at a public mental health clinic, shot and killed Laura Wilcox, a receptionist at the clinic. See *Carry out "Laura's Law," supra* note 58. Similarly, Michigan enacted "Kevin's Law" after a man with schizophrenia beat to death college student Kevin Heisinger. See Scherer, *supra* note 8, at 397 n.188.

<sup>105</sup> See Swartz et al., *supra* note 26, at 327 (describing effect of IOC on incidence of violence). The study measured violence through reports by the patients and their case managers and included acts or threats of violence. *Id.* Other major factors in violent behavior were substance abuse and infrequent contact with mental health services. *Id.*

<sup>106</sup> See FINAL REPORT, *supra* note 4, at 17-18 (reporting data on incidence of arrest and incarceration among IOC patients). The state reported an eighty-three percent reduction in rates of arrest and an eighty-seven percent reduction in rates of incarceration for patients under an IOC order. *Id.* However, this data does not track the crimes precipitating the prior arrests and incarceration, and includes only non-violent crime. *Id.* In a study of the New York City IOC pilot program conducted prior to Kendra's Law, there were no arrests for violence against a person. Steadman et al., *supra* note 26, at 333 (detailing incidence of arrest among IOC group and control group).

<sup>107</sup> See Dlugacz, *supra* note 11, at 85-87 (assessing effect of media portrayals on debate over Kendra's Law). For example, Andrew Goldstein, Kendra Webdale's killer, voluntarily attempted to seek treatment, only to be turned away. *Id.* at 85. The media largely ignored that fact. *Id.*; see also NAT'L COUNCIL ON DISABILITY, *supra* note 12, at 10 ("Misconceptions about dangerousness are among the justifications that allow the maltreatment and abuse of people with psychiatric disabilities.").

violence than members of the general population.<sup>108</sup> Furthermore, doctors cannot predict with accuracy which individuals are “dangerous,” let alone identify individuals fitting the vaguer standard for preventative IOC; that is, individuals who are likely to deteriorate and become dangerous.<sup>109</sup> Finally, individuals deemed dangerous to themselves or others are already eligible for involuntary commitment as an inpatient.<sup>110</sup> Because IOC laws exist expressly to provide involuntary treatment to patients who are not considered dangerous, protection of the public cannot be considered a main justification for these laws.<sup>111</sup>

A more compelling justification for the use of IOC is the possibility of positive therapeutic outcomes for patients under a court order.<sup>112</sup> The New York State report on Kendra’s Law found that patients’ adherence to medication improved significantly, and found moderate improvement in a variety of measures of social functioning.<sup>113</sup> In the long term, it found that patients subject to a Kendra’s Law order experienced significantly reduced instances of psychiatric hospitalization and homelessness.<sup>114</sup> The North Carolina study also found some link between

<sup>108</sup> See Steadman et al., *supra* note 10, at 393 (finding no significant difference in rates of violence between mentally ill and control group). The strongest indicator of further violence found in the study was substance abuse. *Id.*; see also Honig & Stefan, *supra* note 5, at 112-13 (showing no causal link between mental illness and violence); Scherer, *supra* note 8, at 377 (“[C]ontrary to popular belief, many scientific studies have struggled to find a concrete link between violence and severe mental illness.”).

<sup>109</sup> See Worthington, *supra* note 2, at 239 (citing difficulty of predicting future acts of violence). Worthington suggests that testifying physicians, concerned about the possibility of litigation if a patient who is released commits a violent crime, will tend to overestimate the incidence of dangerousness, allowing individuals to be subject to IOC who do not fit a closer reading of the criteria. *Id.*; see also PERLIN, *supra* note 22, at 80-82 (describing vagueness inherent in prediction of dangerousness).

<sup>110</sup> See Cichon, *supra* note 62, at 337 (citing standard of dangerousness in civil commitment proceedings); PERLIN, *supra* note 22, at 82 (“[S]tate and federal courts have unanimously found dangerousness to be a predicate to a constitutionally valid commitment.”). In many circumstances, the dangerous patient is subject to being involuntarily medicated once committed. Cichon, *supra* note 62, at 337-39.

<sup>111</sup> See Gutterman, *supra* note 36, at 2435-37 (finding preventative IOC not justified by police power because it covers non-dangerous people); MacKeigan, *supra* note 22, at 751-52 (suggesting IOC based on “speculative risk assessments” rather than dangerousness not justified by police power).

<sup>112</sup> See Scherer, *supra* note 8, at 371 (listing statistical positive effects of Kendra’s Law).

<sup>113</sup> See FINAL REPORT, *supra* note 4, at 12 (charting improvements in medication adherence and social functioning). *But see* PERLIN, *supra* note 22, at 94 (casting doubt on medication compliance per se as evidence of social functioning in inpatient context). Courts should not use the fact of whether or not an individual complies with medication to substitute for a determination of the individual’s competence to make treatment decisions or level of social functioning. *Id.* at 94-95.

<sup>114</sup> See FINAL REPORT, *supra* note 4, at 17-18 (reporting 77% decrease in hospitalizations and 74% decrease in homelessness). However, the study of the New York City IOC pilot



IOC and reduced hospitalizations, particularly for long-term patients.<sup>115</sup> While the ability to receive treatment in the community benefits mentally ill people, the question remains whether involuntary outpatient commitment is the most effective way to provide that treatment.<sup>116</sup>

By its very nature, IOC intrudes on the autonomy of the mentally ill individual.<sup>117</sup> In *In re K.L.* and other related cases addressing the issue under Kendra's Law, courts have held that the intrusion is not sufficiently great to overcome the government's interest in treating mentally ill people before their condition may deteriorate.<sup>118</sup> However, the fact remains that preventative IOC, by definition, encompasses individuals who are competent to make decisions about their treatment.<sup>119</sup> Furthermore, even the majority of those individuals deemed seriously mentally ill display the same decision-making competence as mentally healthy people.<sup>120</sup> As much as possible, such people should retain the right to participate in their own treatment decisions.<sup>121</sup>

---

program found no significant difference in hospitalizations or homelessness between the group receiving IOC and a control group receiving enhanced voluntary services. Steadman et al., *supra* note 26, at 333-34.

<sup>115</sup> See Swartz et al., *supra* note 26, at 327 (summarizing data on hospital readmissions). Frequency of contact with services was also a significant factor in reduced hospitalizations. *Id.*

<sup>116</sup> See Winick et al., *supra* note 21, at 190-91 (summarizing therapeutic benefits and drawbacks of IOC). Studies have found that IOC has some success at reducing subsequent hospitalizations, but that the success largely depends on the commitment of treatment resources to the program. *Id.* at 190. IOC also presents a risk of undermining the relationship between doctor and patient due to the threat of coercion. *Id.* at 191.

<sup>117</sup> See Gutterman, *supra* note 36, at 2434-35 (describing civil libertarian opposition to Kendra's Law). Court-ordered medication intrudes on the individual right to determine medical treatment, and the medication itself influences the individual's thought processes. *Id.*

<sup>118</sup> See *In re K.L.*, 806 N.E.2d 480, 484 (N.Y. 2004) (holding Kendra's Law does not constitute forced medication); *supra* Part III (describing constitutional decisions on IOC). *But see* O'Connor, *supra* note 7, at 347 (claiming "the issue is one of semantics" between forced medication and court-ordered medication).

<sup>119</sup> See Gutterman, *supra* note 36, at 2436 (citing lack of incompetency requirement as argument against Kendra's Law); *see also* Winick et al., *supra* note 21, at 193 (suggesting IOC debate in practice assumes incompetence of mentally ill people).

<sup>120</sup> See Grisso & Appelbaum, *supra* note 82, at 169 ("[T]he majority of patients with schizophrenia did not perform more poorly than other patients and nonpatients."). Although a minority of patients with schizophrenia showed substantial decision-making impairment, most were as competent as those in the control group. *Id.*; *see also* Winick et al., *supra* note 21, at 193-94 (discussing legal ramifications of de facto assumption of incompetency).

<sup>121</sup> See O'Connor, *supra* note 7, at 347-48 (criticizing lack of protection under Kendra's Law for patient decision-making). Kendra's Law requires that the respondent have "an opportunity to actively participate in the development of [the treatment] plan." *Id.* at 348 (quoting N.Y. MENTAL HYG. LAW § 9.60(i)(2) (Consol. Supp. 2012)). However, the law provides no guidance on how to accomplish this, leaving the patient with no real decision-making leverage if the doctor creating the plan is opposed to the patient's input. *Id.*; *see also* Strang, *supra* note 2, at 275 (outlining proposal to require formal meeting for discussion of treatment plan).

The individual's right to participate in his or her own treatment decisions becomes even more vital when considering the side effects of commonly-used psychiatric medications, particularly antipsychotics, which are the main component of most IOC orders.<sup>122</sup> One particularly severe side effect is tardive dyskinesia, which is characterized by uncontrollable repetitive movements.<sup>123</sup> Tardive dyskinesia is of particular concern because it is usually irreversible, even when the medication is discontinued.<sup>124</sup> Furthermore, not all patients benefit from antipsychotic medication.<sup>125</sup> Finally, even when antipsychotic medications work well, they do not treat all of the symptoms of schizophrenia.<sup>126</sup> While antipsychotic medications can reduce symptoms in many patients, a patient's decision not to use antipsychotic medication may have more to do with the patient's rational weighing of the options than a symptom of the mental illness.<sup>127</sup>

Ultimately, one of the most important clinical benefits of involuntary outpatient commitment may be the promise of additional funding for treatment that such a program brings.<sup>128</sup> For example, New York devoted \$32 million dollars a year in funding to support programs under Kendra's Law, and each Kendra's Law patient is guaranteed individual case management.<sup>129</sup> Furthermore, New York courts have held that counties are required to finance the cost of court-ordered treatment.<sup>130</sup>

---

<sup>122</sup> See Cichon, *supra* note 62, at 297 (discussing side effects of antipsychotic medication). Antipsychotic medications can cause a variety of effects on the nervous system, including parkinsonism, akinesia (a state of reduced spontaneous mobility combined with extreme apathy), and akathisia (a state of constant agitation and involuntary movement). *Id.* at 300-02. These side effects typically go away when treatment is discontinued, but can be unbearable while they continue. *Id.*

<sup>123</sup> See *id.* at 304-05 (describing symptoms of tardive dyskinesia). The effects are often concentrated in the face, tongue, and mouth, but in serious cases can cause difficulty with breathing. *Id.* Even mild symptoms are obvious and can be socially debilitating. *Id.*

<sup>124</sup> See *id.* at 305 (stating irreversibility of tardive dyskinesia). Estimates of the prevalence of tardive dyskinesia range from between ten and twenty percent to up to fifty-five percent of long-term patients. *Id.* at 306.

<sup>125</sup> See *id.* at 295-96 (describing lack of efficacy of antipsychotic drugs in some cases). As many as fifty percent of patients with chronic schizophrenia, and even some with acute schizophrenia, may derive no benefit from the drugs. *Id.*

<sup>126</sup> See *id.* at 294 (describing limits on effectiveness of antipsychotics).

<sup>127</sup> See Honig & Stefan, *supra* note 5, at 116 ("[A] decision to refuse treatment with antipsychotics . . . might represent a sound medical decision.").

<sup>128</sup> See Dlugacz, *supra* note 11, at 92 (advocating use of IOC statutes to secure services for clients).

<sup>129</sup> See FINAL REPORT, *supra* note 4, at 2 (reporting funding allotments for provision of Kendra's Law services).

<sup>130</sup> See *In re Arden Hill Hosp.*, 703 N.Y.S.2d 902, 907 (N.Y. Sup. Ct. 2000) (holding cost of treatment under Kendra's Law to be borne by county). *But see* Scherer, *supra* note 8, at 420

Because a patient who meets the criteria for an outpatient commitment order is likely to be in need of some form of treatment, advocates could use outpatient commitment laws to ensure that treatment is provided to those who need it most.<sup>131</sup>

Finally, in the debate over outpatient commitment, more attention should be given to the experiences of patients who have been subject to court-ordered treatment.<sup>132</sup> The New York State report on Kendra's Law found that sixty-two percent of patients considered their court-ordered treatment a good thing overall.<sup>133</sup> However, an independent study of patients' perceptions of IOC found that while roughly half of patients were optimistic about the program going in, only 27.6% felt that it had benefited them personally after one year of treatment.<sup>134</sup> People who expressed a positive perception of the treatment order at the beginning of the study were more likely to have beneficial treatment outcomes, suggesting that positive patient involvement is therapeutically beneficial even in the involuntary context.<sup>135</sup> Among patients who reported a strong subjective feeling of coercion, positive treatment outcomes were associated with positive endorsement of IOC, while negative outcomes caused strongly negative assessments.<sup>136</sup> The debate over involuntary outpatient

---

(outlining California counties' responsibility to fund Laura's Law). The requirement that each county provide its own funding for California's Laura's Law has led only one county to adopt it, and on a limited basis only. *Id.* at 421-22.

<sup>131</sup> See Dlugacz, *supra* note 11, at 92-93 (suggesting advocate's role is to ensure IOC recipient receives most appropriate services); Worthington, *supra* note 2, at 238-39 (observing that Kendra's Law concentrates resources on most needy clients). However, some advocates are concerned that IOC will divert funding from voluntary mental health programs. See Allen & Smith, *supra* note 12, at 344 ("Every dollar prioritized for coerced treatment is a dollar that is not available to pay for effective voluntary services . . ."); Worthington, *supra* note 2, at 238 (expressing concerns of Kendra's Law critics). Both voluntary and involuntary patients will benefit from a better-funded mental health system capable of more cohesive services. Swartz et al., *supra* note 26, at 329 (finding therapeutic benefits gained through availability of intensive treatment); Torrey & Zdanowicz, *supra* note 27, at 340 (suggesting IOC will increase available funds by decreasing amount expended on inpatient hospitalizations).

<sup>132</sup> See Honig & Stefan, *supra* note 5, at 117-18 (citing sparse research on patient experiences with IOC).

<sup>133</sup> See FINAL REPORT, *supra* note 4, at 20 (describing experiences of Kendra's Law patients). Even higher percentages of patients reported some benefit from court orders; for example, eighty-one percent felt that it had "helped them get and stay well." *Id.* at 21.

<sup>134</sup> See Winick et al., *supra* note 12, at 78 (stating overall results of study). People who felt positively at the beginning of the study were also more likely to endorse IOC at the end of the study. *Id.* at 80-81. Predictably, people who experienced a positive result from treatment were more likely to report personal benefit. *Id.* at 79-80.

<sup>135</sup> See *id.* at 79-81 (suggesting patients' positive baseline approach to IOC contributed to better response to treatment).

<sup>136</sup> See *id.* at 73 (finding patients' experience of high degree of coercion polarized attitudes towards IOC).

commitment should include these measures of patients' experiences of IOC, and attention should be paid to how individual patients describe the effect of IOC on their lives.<sup>137</sup>

#### IV-B. IMPLICATIONS FOR ADVOCACY

Attorneys representing mentally ill clients have struggled for some time to define their role in the proceedings.<sup>138</sup> Some attorneys maintain the standard adversarial role, advocating for their client's stated interests regardless of the predicted mental health outcomes.<sup>139</sup> Others take a paternalistic approach of advocating for what they consider to be in their client's best interests, even if it goes against the client's expressed wishes.<sup>140</sup> Because people who are eligible for preventative outpatient commitment are, by definition, competent to make their own treatment decisions, lawyers in the IOC context should act as much as possible according to their client's stated goals.<sup>141</sup> This is particularly so given the therapeutic benefits to the client in participating in his or her own treatment process.<sup>142</sup>

However, the attorney can play an important role in mediating between the mentally ill client and the party proposing involuntary

<sup>137</sup> See Honig & Stefan, *supra* note 5, at 120-21 (suggesting studies of IOC should evaluate subjective impact of IOC on patient); see also NAT'L COUNCIL ON DISABILITY, *supra* note 12, at 9 (arguing for self-determination and consumer direction in mental health services).

<sup>138</sup> See Abisch, *supra* note 13, at 120-22 (discussing adversarial and best-interests approaches to representation); Yale Note, *supra* note 13, at 1542-43 (outlining potential roles for advocate in civil commitment proceeding).

<sup>139</sup> See Yale Note, *supra* note 13, at 1554-55 (arguing lawyers for mentally ill clients should take adversarial role in civil commitment process). As in other areas of the legal system, the adversarial model is premised on the idea that the competing interests of each side will produce a result closest to the truth. *Id.*

<sup>140</sup> See Abisch, *supra* note 13, at 129-31 (detailing argument that attorney should act in client's best interests to ensure beneficial treatment). The pitfall of this position is that a lawyer attempting to act in the best interests of his client may simply follow the word of doctors and hospital administrators, and, thus, fail to consider the individualized situation of the client. See *id.* at 131.

<sup>141</sup> See Dlugacz, *supra* note 11, at 92 (suggesting role for attorney as advocate in IOC proceedings). The Model Rules of Professional Conduct state that when representing a client with a mental impairment, the attorney should maintain a normal attorney-client relationship as much as possible. MODEL RULES OF PROF'L CONDUCT R. 1.14(a) (2009). In the context of a client who is competent to make treatment decisions, this entails advocating for the goals chosen by the client. See Abisch, *supra* note 13, at 139 (setting out obligation of attorney under Model Rules).

<sup>142</sup> See Winick et al., *supra* note 21, at 206 (suggesting therapeutic benefits from Kendra's Law).

outpatient commitment.<sup>143</sup> The advocate employing mediation techniques, while keeping in mind the client's objectives, can enhance the client's role in the decision-making process and advocate for treatment in a form that is more amenable to the client.<sup>144</sup> In a situation where the client cannot realistically avoid an outpatient commitment order, a lawyer employing mediation techniques may be able to help the client obtain treatment in a form the client is willing to accept.<sup>145</sup> Furthermore, the cooperative process mediation may benefit the client's relationship with his or her physician by encouraging a relationship of trust.<sup>146</sup> However, even when employing mediation, the attorney must keep in mind the objectives of his client and support the client if a dispute cannot be resolved.<sup>147</sup> In addition, the restrictions that exist within the hearing process itself may limit the attorney's ability to engage in mediation.<sup>148</sup>

Some clients may benefit from an outpatient commitment order even though they consent to treatment.<sup>149</sup> For example, some patients' awareness of their mental illness fluctuates over time, and, therefore, their willingness to continue treatment also changes.<sup>150</sup> Such patients may seek an outpatient commitment order during a period of greater mental capacity to ensure that they continue treatment during periods when they are unable to perceive their need for it.<sup>151</sup> Other clients may wish to undergo treatment in the community but cannot consistently perform tasks such as

---

<sup>143</sup> See Chen, *supra* note 13, at 610-11 (outlining mediation-based approach to mental health representation); see also Dlugacz, *supra* note 11, at 92-93 (suggesting IOC may be useful in obtaining services for voluntary clients).

<sup>144</sup> See Dlugacz, *supra* note 11, at 92-93 (prescribing role of advocate in obtaining services more acceptable to client); Chen, *supra* note 13, at 611-12 (arguing for mediation approach to obtain less restrictive services for client).

<sup>145</sup> See Dlugacz, *supra* note 11, at 92-93 (suggesting participation in treatment plan may increase clients' willingness to undergo treatment).

<sup>146</sup> See Chen, *supra* note 13, at 610-11 (arguing mediation avoids destructive effect of adversarial proceedings on client's relationship with doctor). This is only the case if the client's doctor is amenable to participating in the mediation process. *Id.* at 611.

<sup>147</sup> See Abisch, *supra* note 13, at 136-37 (emphasizing that mediational lawyer does not have neutral role but represents interests of client).

<sup>148</sup> See Winick et al., *supra* note 21, at 197 (stating time period in Kendra's Law petitions places limitation on advocacy). In Kendra's Law proceedings, a hearing must be held within three days and can take place in the absence of the client, making it difficult or impossible for the attorney to adequately communicate with the client. *See id.*

<sup>149</sup> See Dlugacz, *supra* note 11, at 92 (suggesting advocate obtain most suitable treatment plan for willing client).

<sup>150</sup> See Torrey & Zdanowicz, *supra* note 27, at 337-38 (describing patients' fluctuating awareness of condition). Some patients feel that they are "better" after a period of being on medication and therefore discontinue the medication, worsening their condition. *See id.*

<sup>151</sup> *See id.* at 339-40 (stating patients may seek to authorize treatment in advance in case of future need).

going to appointments or filling prescriptions.<sup>152</sup> Such clients are likely to benefit significantly by outpatient commitment, as it allows them to obtain oversight of their treatment while living in the community.<sup>153</sup> In this context, the advocate's role is to ensure that the treatment provided is appropriate to the client's needs.<sup>154</sup>

In some cases, clients may be unable to avoid an IOC order despite their objections.<sup>155</sup> In this case, the advocate can determine the nature of the client's objection to treatment and assist the client in obtaining alterations to the treatment plan to make it more amenable.<sup>156</sup> For example, if a patient objects to a particular medication, the advocate can aid the client in substituting a different medication or lowering the dosage.<sup>157</sup> The advocate can also attempt to procure non-medication services, which may help the client gain control over his or her symptoms.<sup>158</sup>

In order to give attorneys the ability to advocate on behalf of their clients, OPC statutes should be constructed to protect the procedural rights of patients.<sup>159</sup> At a minimum, statutes should provide the patient the right to counsel and the ability to provide input into the ordered treatment.<sup>160</sup> However, even when these rights are protected, the context of the hearings may still produce barriers to client-centered advocacy.<sup>161</sup> For example,

<sup>152</sup> See Scherer, *supra* note 8, at 375-76 (describing symptoms of severe mental illness). People with severe mental illness often suffer deficits in attention and cognition that can lead to difficulty with daily tasks. *Id.* at 375.

<sup>153</sup> See Winick et al., *supra* note 21, at 206 (noting avoidance of hospitalization and input into treatment plan as therapeutic aspects of Kendra's Law).

<sup>154</sup> See Dlugacz, *supra* note 11, at 92-93 (suggesting advocate's role may include securing more services for client).

<sup>155</sup> See PERLIN, *supra* note 22, at 90-91 (noting ease of obtaining commitment order in inpatient commitment context). Because testimony in commitment proceedings often hinges on the respondent's likelihood to self-medicate, the client's opposition may paradoxically cause him or her to be seen as especially in need of a commitment order. *Id.* at 92-93.

<sup>156</sup> See Dlugacz, *supra* note 11, at 92-93 (suggesting patient may be more likely to accept treatment plan when involved in creating it); see also N.Y. MENTAL HYG. LAW § 9.60(i)(2) (Consol. Supp. 2012) (guaranteeing respondent opportunity to participate in treatment plan).

<sup>157</sup> See Dlugacz, *supra* note 11, at 92 (recommending advocate should closely examine services prescribed in treatment plan).

<sup>158</sup> See FINAL REPORT, *supra* note 4, at 11 (listing services provided to Kendra's Law recipients). Seventy-five percent of people under a Kendra's Law order participated in therapy, while thirty-one percent received housing or housing supervision. *Id.*

<sup>159</sup> See Dlugacz, *supra* note 11, at 90-91 (emphasizing role of advocates in IOC proceedings).

<sup>160</sup> See Torrey & Zdanowicz, *supra* note 27, at 340 (arguing for patient's right to counsel in defense of IOC); O'Connor, *supra* note 7, at 340-41 (emphasizing importance of right to counsel in context of Kendra's Law).

<sup>161</sup> See O'Connor, *supra* note 7, at 341-42 (summarizing barriers to effective representation); Strang, *supra* note 2, at 274-76 (outlining proposals to refine proposed Ohio statute).

Kendra's Law hearings must take place within three days of the petition, leaving little time for the attorney to prepare the case and making it difficult even to meet with the client before the hearing.<sup>162</sup> Similarly, although Kendra's Law provides for the right to participate in the treatment plan, the physician may submit the treatment plan at the hearing, leaving the advocate with no chance to discuss its terms with the client or to attempt to negotiate outside of the adversarial context.<sup>163</sup> In order to protect the patient's right to self-determination as much as possible, the opportunity to participate should be protected by ensuring a procedure for the patient to contribute to the treatment plan before it is presented to the court.<sup>164</sup> Finally, to ensure consideration of the patient's autonomy in practice, both petitioners and courts must come to reject presumptions of the patient's incompetence and respect their ability to provide input into their own treatment.<sup>165</sup>

## V. CONCLUSION

For the moment, courts appear willing to uphold the constitutionality of IOC statutes. However, these statutes nevertheless allow a significant intrusion into the autonomy of mentally ill individuals. In order to provide protection to people subject to IOC, statutes should provide procedural safeguards, including the right to an attorney and the ability to provide substantive input into the treatment plan. Furthermore, the hearing process must be structured in a way that protects the subject's ability to exercise his or her rights in practice. Finally, attorneys for people subject to an IOC petition must be prepared to take an active role in protecting the autonomy interests of their clients. Attorneys should advocate for their clients' stated objectives and, to the extent possible,

---

<sup>162</sup> See Winick et al., *supra* note 21, at 197 (setting out limitations of time period on effective advocacy).

<sup>163</sup> See O'Connor, *supra* note 7, at 341-42 (pointing out treatment plan can be submitted at time of hearing). When the physician writes the treatment plan without consulting the patient and the court must make its decision on the plan as written, the patient's opportunity to participate in the treatment plan is unlikely to substantively effect treatment options. See *id.* at 347-49.

<sup>164</sup> See *id.* at 348 (arguing "opportunity to actively participate" does not sufficiently protect patient's interest); Strang, *supra* note 2, at 275 (proposing requirement of formal meeting between patient and physician for Jason's Law). Strang proposes that the patient be given a formal meeting with the examining physician to discuss the treatment plan before the hearing, although he stops short of allowing the patient veto power over portions of the plan. Strang, *supra* note 2, at 275. A similar solution could be to give the patient limited veto power if he or she proposes an equally effective treatment. *Id.*

<sup>165</sup> See Winick et al., *supra* note 21, at 194-95 (arguing courts engage in implied presumption of incompetency during hearings on treatment).

assist clients in exercising their right to determine the proper course of treatment.

*R. A. Bernfeld*